No. 83-1149

Supreme Court of the United States

October Term, 1983

MARGARET M. HECKLER, Secretary of Health and Human Services, et al.,

Petitioners,

vs.

EULA B. STARNES, et al.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Court of Appeals correctly decided to uphold the District Court's exercise of subject matter jurisdiction under 28 U.S.C. § 1331 to enjoin the Secretary's further implementation of arbitrary caps on Medicare Part B reimbursement for covered medical services that were established in violation of the procedural rulemaking requirements of the Administrative Procedure Act (5 U.S.C. § 533)?

2. Whether the District Court has jurisdiction under 28 U.S.C. § 1331 to review respondents' procedural constitutional and statutory challenges to the Secretary's unlawful conduct in the administration of the Medicare Part B program, as held by the Court of Appeals?

3. Whether the District Court has jurisdiction under 28 U.S.C. § 1361 to review respondents' rulemaking challenge and their constitutional and statutory challenges to the Secretary's administration of the Medicare Part B program, as held by the Court of Appeals?

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STATUTORY PROVISIONS INVOLVED

5 U.S.C. § 553 is reproduced at App., *infra*. Other relevant statutes are reproduced in App. F to the Secretary's petition.

STATEMENT OF CASE

The matter presently before the Court on petition for writ of certiorari is the product of administrative arrogance, attempted defiance of clear Congressional mandates, and scorn for judicial supervision. Acting with flagrant disregard of the procedural safeguards embodied in the rulemaking requirements of the Administrative Procedure Act ("APA"), 5 U.S.C. § 553, and constitutional and statutory mandates guaranteeing due process and fairness in the administration of the Medicare Part B program, the Secretary during 1977-78 imposed arbitrary caps on reimbursement under Medicare Part B for covered CT scanning services, effectively eliminating the provision of such services in physicians' offices and forcing Medicare beneficiaries to obtain CT scans, if at all, in hospitals where the services were costlier and resulting delays were sometimes life threatening.

As recently recognized by this Court, Congress intended for private insurance carriers to play a central role in administering Medicare Part B and in providing beneficiaries with fair hearings on benefit controversies through carrier-appointed hearing officers. *Schweiker v. McClure,* 456 U.S. 188 (1982). These statutory functions of Part B carriers were usurped with respect to CT scanning services through the abusive administrative actions of the Secretary taken over strong objections of carriers throughout the nation and contrary to the advice of the Secretary's own counsel that the imposition of the caps would be illegal if not subjected to rulemaking and shown during the rulemaking process to be reasonable.

For such administrative misconduct, the Secretary seeks absolute and unquestioned immunity from judicial review. In this pursuit, the Secretary mischaracterizes the nature of respondents' action as one challenging the appropriateness of the amount of benefits paid on claims for CT scans under Medicare Part B. This mischaracterization of the case is an essential element of the Secretary's argument that 42 U.S.C. §§ 405(h) and 1395ff are bars to the exercise of subject matter jurisdiction over respondents' challenges. The Secretary's position, simply stated, is that she should have free rein to act as arbitrarily as she desires, without concern for judicial intervention, with respect to matters having any direct or indirect bearing upon the Medicare Part B program.

Contrary to the Secretary's misleading statement of the case, respondents have not challenged the reasonableness of the amount of benefits paid for CT scans. Respondents seek the aid of the judicial system only to ensure that Part B is administered according to the procedures established by Congress and pursuant to lawfully promulgated regulations; they do not seek monetary relief. If the Medicare program is lawfully administered, then respondents will be satisfied with the amounts of benefits determined to be allowable through the statutory carrier review and hearing process, whatever those determinations may be.

Drawing upon a substantial body of case law, including recent decisions of this Court, the District Court and the Court of Appeals have on three occasions during the past five years rejected the Secretary's plea for an absolute bar to judicial review of respondents' challenges. In

her petition the Secretary attempts again to resurrect the issue of jurisdiction and to prolong further a final determination on the merits. The case law provides overwhelming support for judicial review under 28 U.S.C. §§ 1331 and 1361. Thus, the Secretary's petition should be denied.

1. *Medicare Part B.* The Medicare program, a health insurance program for the aged and disabled, consists of two basic components, Parts A (42 U.S.C. §§ 1395c *et seq.*) and B (42 U.S.C. §§ 1395j *et seq.*). Generally, Part A provides insurance for hospital and other specified institutional health care. Part B, which is involved in this action, provides insurance for covered medical services of physicians and other specified suppliers.

Respondents accept the Secretary's general description of Part B and its administration by Part B carriers (Pet. for Cert. 2-4), with the exception of the following clarification of certain misstatements and key omissions.

In making "reasonable charge" determinations, carriers are required by statute to apply two statutory limitations: (a) "customary" charges for similar services generally made by the physician who furnishes the services; and (b) the "prevailing" charges in the locality for similar services. 42 U.S.C. § 1395u (b) (3). Customary and prevailing charge screens are established by the carriers for this purpose. If a physician's actual charge for a service does not exceed the customary and prevail-

ing charge limitations, the actual charge is the "reasonable charge" and the basis for payment of benefits by the carrier.[1]

By regulation, the Secretary has acknowledged the statutory mandate that carriers, rather than government officials, are to "exercise judgment" on a case-by-case basis in making reasonable charge determinations. 42 C.F.R. §§ 405.502(c), 405.502(d). These determinations are to be made in accordance with broad "principles" issued by the Health Care Financing Administration ("HCFA"), the component of the Department of Health and Human Services ("HHS") responsible for the Medicare program. 42 C.F.R. § 405.502(d). The Secretary asserts that such principles are contained in "regulations and policy guidelines" issued through HCFA. Pet. for Cert. 3. The Secretary's regulation clearly states, however, that "[t]he *principles* in §§ 405.503-405.507 establish the criteria for making such determinations in accordance with the statutory provisions." 42 C.F.R. § 405.502(d) (emphasis added). Thus, the regulations limit the principles by which carriers are guided in exercising their discretion to those published in the regulations at §§ 405.503-405.507, and those sections of the regulations relate solely to the "customary" and "prevailing" charge criteria prescribed by statute for reasonable charge determinations. There is no authority in the statute or regulations for carriers to be guided by "policy guidelines" that are not lawfully promulgated in the regulations.

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[1]The statute also imposes an "economic index" limitation on annual increases in the prevailing charge limitation for physician services. 42 U.S.C. § 1395u (b) (3). The CT scan caps in question are not based on the economic index limitation. In fact, the caps rendered the economic index limitation meaningless with respect to CT scanning services.

As the Secretary acknowledges, the carrier review and hearing process prescribed by statute is restricted to beneficiary (or assignee) dissatisfaction with the carrier's initial determination as to the allowable amount of benefits. 42 U.S.C. § 1395u (b) (3) (C); 42 C.F.R. §§ 405.801(a), 405.807. The Secretary conspicuously fails to note, however, that the statute requires that beneficiaries be afforded a "fair" hearing when an amount of $100 or more is in controversy, and that the Secretary has bound carrier-appointed hearing officers to comply with "policy statements, instructions and other guides" issued by HCFA. 42 C.F.R. § 405.860.

Unlike many reimbursement disputes under Part A, disputes as to the proper amount of benefits allowable under Part B are not subject to judicial review under the statute. Beneficiaries must rely upon the carrier or a carrier-appointed hearing officer to make a fair and lawful determination on that subject.

2. *Background of the CT dispute.* Computerized tomography ("CT") scanning, also known as computerized axial tomography ("CAT"), is a highly effective diagnostic tool for a variety of cranial disorders (*e.g.*, tumors, atrophy, hemorrhage, skull fractures) the use of which enables the elimination of other time-consuming, painful, less effective, riskier, and more costly diagnostic procedures. The developers of CT scanning were recognized with the award of the 1979 Nobel Prize in Physiology or Medicine.

CT head scanning became a covered service under Medicare Part B in 1976.[2] At that time, carriers based reasonable charge determinations for CT head scans on the actual charges of physicians, subject to the customary and prevailing charge criteria that were then, and still are, prescribed in the statute and the Secretary's regulations.

In July 1977, the Region Office (Atlanta) of the Medicare Bureau (the predecessor to HCFA) first established caps on Part B reimbursement for CT head scans at $150 through letters issued to all carriers in Region IV. A $150 nationwide cap was then established by the Medicare Bureau in December 1977, by a memorandum issued to all Regional Medicare Directors. The Medicare Bureau slightly adjusted the nationwide caps in September 1978, through the issuance of Intermediary Letter 78-38 to all Part B carriers. The Intermediary Letter adjusted the caps to $157.50 or $172.50 depending upon the use of contrast enhancement. These caps have never been subjected to formal rulemaking.

Upon establishment of the caps, carriers throughout the United States questioned their legality, challenged them as being inequitable and unreasonable, and request-

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[2]The Secretary references the portion of the March 1978 National Guidelines for Health Planning pertaining to CT scanning. (Pet. for Cert. 5). The Secretary fails to note that those Guidelines applied only to hospital-based scanners, which are subject to Part A reimbursement, and ignores the fact that those Guidelines were subsequently withdrawn by the Secretary with the embarrassing admission that they did not take into account the state-of-the-art of CT scanning; they were rigid and inflexible; and they had obstructed the distribution of "needed" scanners, "thus inhibiting access to necessary CT scanning services and preventing the public from fully benefiting from their potential." 47 *Fed. Reg.* 53853 (1982).

ed approval of exceptions, but to no avail. (C.A. App. 79-81, 87-94, 96-102). The President of one of the carrier defendants in this action testified that "[a]s a result of these ceilings, the duties of this defendant are purely ministerial and this defendant is not permitted to exercise any discretion in connection with them." (C.A. App. 144).

Named respondents and members of the respondent classes throughout the United States challenged the caps through the carrier review and hearing process prescribed by statute and regulations. In each case, the carriers and hearing officers concluded that they had no discretion to ignore the caps. When they considered doing so, they received direct instructions from HCFA officials to apply the caps. (C.A. App. 122-128, 152-53, 164-91, 202-14).

In addition to pursuing individual appeals to carrier-appointed hearing officers, respondents, individually and through representative national organizations, sought administrative relief from the caps through extensive discussions with, and written submissions to, HCFA Region IV and then to the Secretary at the national level during the period 1977-79, but to no avail. (C.A. App. 204-05).

During the same period, in August 1978, the chief counsel for HCFA advised the HCFA Administrator that, in order to establish the caps lawfully, HCFA "will have to (1) proceed by rulemaking rather than by intermediary letter and (2) make a case in the rulemaking record for why the caps selected are reasonable." (C.A. App. 37). That legal opinion was ignored. A subsequent warning from the Director of the Medicare Bureau to the HCFA Administrator that "[w]e are already on notice that the Office of General Counsel considers the guidelines that

we recently issued on payment limits for CT scans legally unsupportable" also fell on deaf ears. (C.A. App. 110).

3. *Judicial proceedings below.* Having no avenue of relief available except resort to the courts, respondents brought this action in November 1979. Respondents asserted that the caps were established in violation of the procedural rulemaking requirements of the APA. (C.A. App. 17). Challenges to the Secretary's action were also brought on other grounds. Respondents raised constitutional due process and equal protection challenges, attacking the procedure by which the caps were enforced and implemented and their arbitrary and discriminatory nature. (C.A. App. 16-17). Respondents further contended that the procedure by which Part B determinations are made under the caps is contrary to the Medicare statute and regulations. (C.A. App. 9-10).

Respondents sought injunctive relief from further implementation of the caps and for an order directing that determinations as to Part B reimbursement for CT head scan services be made by Part B carriers without regard to the Secretary's caps. (C.A. App. 20-21). Respondents did not seek to recover on any claim for Part B benefits; no monetary relief was requested.

Finding that the Secretary's establishment of the caps violated the procedural rulemaking requirements of the APA, the District Court entered an Order on March 6, 1980, granting respondents' request for a preliminary injunction.[3] The District Court enjoined further implementation of the caps "until such time, if any, as the

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[3]The unpublished Orders of the District Court are attached as Appendices to the Secretary's petition.

Secretary may lawfully promulgate regulations authorizing HEW [the predecessor to HHS] to set specific reimbursement caps for CT head scan services." (C.A. App. 141-42). Jurisdiction was founded upon 28 U.S.C. § 1331 with respect to the APA rulemaking challenge.[4] No decision was reached on the merits in the March 6, 1980 Order with respect to the other challenges presented by respondents.

Notwithstanding the representations of her counsel to the District Court in December 1979, that appropriate regulations were being drafted for promulgation, the Secretary has never promulgated regulations authorizing the caps. Accordingly, the March 6, 1980 preliminary injunction remains in effect.

An interlocutory appeal, to which this matter relates, was brought by the Secretary to the United States Court of Appeals for the Fourth Circuit in response to a subsequent Order entered by the District Court on April 16, 1982, denying the Secretary's motion to dismiss for lack of subject matter jurisdiction. (C.A. App. 155-63). The District Court reaffirmed its finding of federal question jurisdiction over the APA rulemaking claim and added that judicial review would be appropriate for other challenges brought by respondents to the establishment of the caps. (C.A. App. 161-62). The District Court certified the issue of subject matter jurisdiction to the Court of Appeals.

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[4]Having found jurisdiction to exist under 28 U.S.C. § 1331, the District Court did not address the availability of mandamus jurisdiction under 28 U.S.C. § 1361.

On interlocutory appeal to the Fourth Circuit of the jurisdictional issue, the Secretary contended that 42 U.S.C. §§ 405(h) and 1395ff are absolute bars to judicial review of any conduct of the Secretary having any direct or indirect impact on the administration of Medicare Part B, even if the action arises under the procedural rulemaking provisions of the APA, on constitutional grounds, or is otherwise collateral to benefit determinations. Drawing upon a substantial body of case law, the Court of Appeals disagreed and affirmed the District Court's exercise of jurisdiction over the APA rulemaking claim under 28 U.S.C. § 1331. *Starnes v. Schweiker*, 715 F.2d 134, 140-41 (4th Cir. 1983). Further, the Fourth Circuit concluded that respondents' alleged violations by the Secretary of the Medicare statute and of their constitutional rights were subject to federal question jurisdiction since those claims were essentially to enforce lawful conduct on the part of the Secretary rather than to recover benefits. 715 F.2d at 141.[5]

The Fourth Circuit also concluded that mandamus jurisdiction would be available under 28 U.S.C. § 1361 to decide respondents' challenges if federal question jurisdiction were not available, pointing to "an impressive array of cases" upholding mandamus jurisdiction to review procedures employed in administering social security benefits. 715 F.2d at 141-42. The Court of Appeals observed

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[5]Although the Fourth Circuit determined that respondents' action was not one to recover benefits, it observed that an action to reopen past benefit determinations under Part B on constitutional grounds would be subject to judicial review, notwithstanding 42 U.S.C. § 1395ff and this Court's decision in *United States v. Erika, Inc.*, 456 U.S. 201 (1982), noting that no constitutional issue was pressed before this Court in *Erika*.

that the traditional conditions for the exercise of mandamus jurisdiction may be met in this case if federal question jurisdiction is not available, pointing out that respondents have exhausted all available administrative remedies as well as some informal extra-judicial ones. 715 F.2d at 142.

REASONS FOR DENYING THE WRIT

I. The Decision of the Court of Appeals Finding Jurisdiction Under 28 U.S.C. § 1331 Is Not Inconsistent With Prior Decisions of This Court.

In her petition the Secretary ignores the true nature of respondents' action and with calculated precision mischaracterizes the action as "a challenge to the amount determined to be the 'reasonable charge' under Part B of the Medicare Program" for CT scans. Pet. for Cert. 4. Working from this faulty premise, the Secretary argues that judicial review of respondents' challenges is foreclosed by 42 U.S.C. §§ 405(h) and 1395ff, relying upon this Court's decisions in *Weinberger v. Salfi*, 422 U.S. 749 (1975), and *United States v. Erika, Inc.*, 456 U.S. 201 (1982). The statutory provisions which form the springboard for the Secretary's argument are inapplicable to the present case.

This is not an action challenging "the amount of benefits payable for CT scans," contrary to the Secretary's self-serving mischaracterization. Pet. for Cert. 11. As described above, the appropriate amount of benefits is not an issue here at all. It would be an issue for carrier determination, outside the judicial process, only if respondents' action is successful. Instead, respond-

ents challenge the very conduct of the Secretary which has precluded carriers from performing their duty to make reasonable charge determinations of the amount of benefits for CT scans in accordance with the governing statute and regulations.

The District Court's exercise of jurisdiction over respondents' APA procedural rulemaking challenge is supported by an abundance of authority, notwithstanding 42 U.S.C. § 405(h). The courts have consistently held that APA procedural rulemaking challenges by Medicare claimants to actions taken by the Secretary without notice, opportunity to comment, and publication in the *Federal Register* are subject to judicial review under 28 U.S.C. § 1331.[6] *E.g., National Ass'n of Home Health Agencies v. Schweiker*, 690 F.2d 932 (D.C. Cir. 1982), *cert. denied*, 103 S.Ct. 1,193 (1983); *Daniel Freeman Memorial Hospital v. Schweiker*, 656 F.2d 473, 476 (9th Cir. 1981); *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1,070, 1,080-81 (D.C. Cir. 1978). Such actions seek to vindicate an interest in procedural irregularity, rather than to recover on a claim arising under the Medicare statute as barred by 42 U.S.C. § 405(h). Moreover, a rulemaking challenge is an action arising under 5 U.S.C. § 553, rather than under the Medicare statute.

Similarly, there is no basis for asserting that *Erika* interprets 42 U.S.C. § 1395ff to preclude an APA rulemaking challenge to actions of the Secretary. Unlike the

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[6]The notice and comment requirements "were designed to assure fairness and mature consideration of rules of general application." *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759, 764 (1969). The rulemaking proceeding is intended to provide "procedural" protection. *Heckler v. Campbell*, 103 S.Ct. 1,952, 1,959 (1983).

present case, *Erika* involved a direct challenge to the determination of a carrier-appointed hearing officer as to the amount of benefits awarded to a supplier of medical services. The plaintiff's action in *Erika* was filed in the Court of Claims, and jurisdiction was asserted under The Tucker Act, 28 U.S.C. § 1491. No APA procedural rulemaking challenge was brought.

Recognizing the limited scope of the plaintiff's substantive challenge to the carrier's benefit amount determination, this Court narrowly framed the issue in *Erika* as follows:

> The question is whether the Court of Claims has jurisdiction to review determinations by private insurance carriers of the amount of benefits payment under Part B of the Medicare statute. 456 U.S. at 201.

The Court's opinion focused upon the statutory language of 42 U.S.C. § 1395ff and legislative history indicating Congressional intent not to authorize judicial review of Part B controversies as to the allowable "amount" of benefits. That discussion and the decision in *Erika* are inapplicable to respondents' APA rulemaking challenge. Neither 42 U.S.C. § 1395ff nor its legislative history even hint that Congress intended to bar judicial review of APA rulemaking claims because they might have an effect on the administration of Part B.

Similarly, there is nothing in the text or legislative history of 42 U.S.C. §§ 405(h) and 1395ff to suggest that judicial review under 28 U.S.C. § 1331 of the other procedural challenges brought by respondents to the Secretary's abusive administration of Part B with respect to CT scanning services is foreclosed. The Secretary's argument to that effect conflicts with this Court's decision in *Schweiker v. McClure*, 456 U.S. 188 (1982).

In *McClure*, a case decided on the same day as *Erika*, this Court implicitly recognized that procedural claims brought by Medicare Part B claimants are reviewable. The Court considered the merits of an action challenging the constitutionality of the Part B review and hearing process in *McClure*. Although the plaintiffs failed to succeed on the merits, this Court's consideration of the merits of their claim and its failure to question subject matter jurisdiction to consider the merits implicitly affirmed the lower court's determination that the plaintiffs' constitutional claims were collateral to their substantive claims for Medicare benefits and were therefore reviewable under the authority of *Mathews v. Eldridge*, 424 U.S. 319 (1976). *See McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980).

The exercise of jurisdiction over procedural challenges to the Secretary's conduct in the administration of the Medicare program notwithstanding a statutory bar to judicial review of substantive benefit determinations is also supported by a substantial body of circuit court decisions. *E.g., Hollingsworth v. Harris*, 608 F.2d 1,026, 1,027 (5th Cir. 1979); *Chelsea Community Hospital, SNF v. Michigan Blue Cross Ass'n*, 630 F.2d 1,131, 1,135 (6th Cir. 1980); *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283, 291-92 (8th Cir.), *cert. denied, sub nom., Faith Hospital Ass'n v. Blue Cross Hospital Services, Inc.*, 429 U.S. 977 (1976).

Finally, it is important to recognize that, unlike Medicare Part A and Title II disputes under the Social Security Act, there is no prescribed statutory procedure culminating in judicial review of Medicare Part B claims. Statutory foreclosure of judicial review of all challenges

to the Secretary's administration of Part B would be extraordinary and would be of disputable constitutionality. *Weinberger v. Salfi*, 422 U.S. 749, 762 (1975); *Johnson v. Robinson*, 415 U.S. 361, 366-67 (1974).

Salfi and its progeny of Title II cases, which have been relied upon by the Secretary as support for her assertion that 42 U.S.C. § 405(h) is an absolute bar of all judicial review, clearly indicate otherwise. In *Salfi* and *Mathews v. Eldridge*, 424 U.S. 319 (1976), the merits of the claims presented in those cases *were* addressed by this Court, and, as noted above, courts have subsequently interpreted *Eldridge* to authorize judicial review of procedural claims. Indeed, in *Califano v. Sanders*, 430 U.S. 99, 109 (1977), the Court pointed out that judicial review was available to the plaintiffs in *Salfi* and *Eldridge* under the statutory scheme in question and that an absolute bar to judicial review would presumably be unconstitutional, notwithstanding 42 U.S.C. § 405(h).

Thus, the decision of the Fourth Circuit finding jurisdiction under 28 U.S.C. § 1331 is entirely consistent with prior decisions of this Court.

II. The Decision of the Court of Appeals Finding Jurisdiction Under 28 U.S.C. § 1361 is Supported By Ample Case Law.

If jurisdiction were not available under 28 U.S.C. § 1331, mandamus jurisdiction would be available under the particular facts of this case under 28 U.S.C. § 1361. The federal mandamus statute, added by the Mandamus and Venue Act of 1962, 76 Stat. 744, provides an independent grant of jurisdiction to halt illegal action by federal officials:

> The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff. 28 U.S.C. § 1361.

The writ of mandamus may issue when there is (a) a clear right in the plaintiff to the relief sought; (b) a clear duty on the part of the defendant to do the act in question; and (c) no other adequate remedy available. *E.g., Burnett v. Tolson*, 474 F.2d 877 (4th Cir. 1973).

Respondents have demonstrated through their challenges to the establishment of the caps under APA rulemaking provisions and the Medicare statute and on constitutional grounds that the first two conditions of the mandamus test are met. Respondents' position is bolstered by the observations of carriers throughout the country that the caps are illegal, unreasonable, and inequitable and the Opinion of the Secretary's Office of General Counsel that the caps were not adopted in accordance with APA procedural rulemaking requirements. Indeed, the District Court has already upheld respondents' APA procedural rulemaking challenge on the merits. Further, as reasoned by the Fourth Circuit, the third condition is met if federal question jurisdiction is not available, especially since respondents have exhausted all available administrative remedies.

There is ample authority that mandamus jurisdiction will lie to review actions of the Secretary, notwithstanding 42 U.S.C. § 405(h). For an extensive analysis of the pertinent legislative history and prior case law see Judge Friendly's opinion in *Ellis v. Blum*, 643 F.2d 68 (2d Cir. 1981). *Accord, Kuehner v. Schweiker*, 717 F.2d 813 (3d Cir. 1983).

III. The Court Should Not Grant The Writ and Hold It On The Basis Of The Court's Consideration Of Issues Raised In Heckler v. Ringer, No. 82-1772 (Oct. Term, 1983).

In support of her petition, the Secretary further argues that this Court should grant the writ and hold the petition while it considers issues raised in a case presently before the Court styled *Heckler v. Ringer*, No. 82-1772 (Oct. Term, 1983). Arguing that the identical issue of jurisdiction under 28 U.S.C. §§ 1331 and 1361 is raised in *Ringer*, the Secretary implies that the Court's decision in *Ringer* would control the Court's determination in this case. A comparison of the facts and issues raised in *Ringer* with those in the instant case reveals the fallacy of the Secretary's position.

In contrast to the present case, *Ringer* involves a challenge by claimants to the Secretary's denial of reimbursement under Part A of the Medicare program. As explained by the Secretary in her brief in *Ringer*, Part A provides a significantly different scheme from that found in Part B for both administrative and judicial review. (Petitioner's Brief 3-5). Under 42 U.S.C. § 405(g), as incorporated by 42 U.S.C. § 1395ff(b) (1), a beneficiary is entitled to judicial review when there has been a final decision by the Secretary after a hearing on the claim for benefits. Administrative hearings of the type at issue in *Ringer* are conducted by Administrative Law Judges and are appealable to an Appeals Council prior to judicial review. Carriers and carrier-appointed hearing officers are not part of that process.

The Secretary's and the claimants' briefs in *Ringer* are largely devoted to the central issue of whether the

claimants satisfied the administrative prerequisite to judicial review imposed by 42 U.S.C. § 405(g) by either exhausting their administrative remedies or obtaining a waiver of the exhaustion requirement from the Secretary. The issue of exhaustion of administrative remedies as required by § 405(g) is unique to *Ringer* and the claimants' challenge under Part A. Exhaustion of administrative remedies is not an issue here.

Furthermore, unlike this case, the plaintiffs in *Ringer* did not press their APA rulemaking claim, and it was not considered by the courts below. The principal claim urged by respondents in the instant case is an APA procedural rulemaking claim which, as demonstrated above, is clearly not foreclosed by the provisions of the Social Security Act upon which the Secretary relies.

Accordingly, a decision in *Ringer* will not control the jurisdictional issues in the present case. The Secretary's plea based on *Ringer* appears even more suspect in light of the fact that the Secretary requests that the writ be granted but then held in abeyance. If the Secretary's petition were truly motivated in the present case by a concern over common issues of law, the Secretary's request would undoubtedly seek consolidation of the cases for simultaneous review. The Secretary's request is but another tactic to delay the ultimate determination on the merits in the present case and further aggravate respondents' expenses and injuries. Clearly, no profit could arise from the grant of a writ which would be held until the Court has made a decision on a factually and legally dissimilar case.

CONCLUSION

The Secretary's petition for a writ of certiorari should be denied. If granted, the petition should not be held in abeyance pending a final decision in *Ringer*.

Respectfully submitted,

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APPENDIX A

STATUTORY PROVISIONS INVOLVED[1]

5 U.S.C. § 553 provides:

(a) This section applies, according to the provisions thereof, except to the extent that there is involved —

(1) a military or foreign affairs function of the United States; or

(2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include —

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply —

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

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[1]Other pertinent statutory provisions are presented in Appendix F to the Secretary's Petition.

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except —

(1) a substantive rule which grants or recognizes an exemption or relieves a restriction;

(2) interpretative rules and statements of policy; or

(3) as otherwise provided by the agency for good cause found and published with the rule.

(e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.